CORNERSTONE COUNSELING & CONSULTING SERVICES, LLC

1900 Fairgrove Avenue, Hamilton, OH 45011- Phone: 513-889-5880 Fax: 513-755-1967

Statement of Understanding

WELCOME

Welcome to Cornerstone Counseling and Consulting Services LLC (CCCS). This introductory letter has been prepared to acquaint you with our services. We provide confidential assessment, counseling and treatment services. We look forward to working with you to be sure you receive prompt, effective treatment and regain your health and ability to function safely and productively.

OUR SERVICES

Our goal is to focus on your health and well-being as well as work related issues. Services are provided by licensed therapists with Master's Degrees in counseling, psychology and social work. Our services include assessment, counseling, coordination of treatment, and follow-up. We follow a model of counseling tailored to your specific needs. Each session lasts approximately 50 minutes. If you need other help it may be necessary to make a referral to another professional. When this occurs, it is important that you be aware of the extent of your medical health coverage. Cornerstone is not affiliated with LifeSpan. All services are provided by Cornerstone.

CONFIDENTIALITY

Your counseling records are confidential and secured. Information will not be released to anyone without your written consent except in the following situations:

1) Indication of a clear and present danger of harm to you or other persons.
   - ♦ Child abuse or neglect situation; or
   - ♦ Abuse or neglect of a dependent adult that is in your care; or
   - ♦ Admission of a commission of a crime or a serious health condition that poses a risk to a patient and/or public safety.
2) A court order or other legal order (e.g. a subpoena), or as otherwise required or permitted by law.
3) If you file a complaint or lawsuit against your counselor, your counselor may disclose relevant information about you in order to defend her/himself.

AUTHORIZATION FOR RELEASE OF INFORMATION

In some situations, you will be asked to sign a release of information consent form. The Release of Information form allows CCCS to release only specific information to the individual(s) you specify. This is necessary to coordinate your care and ensure you appropriate assessment and/or treatment.

SERVICES NOT COVERED

It is the policy of CCCS not to participate in client's legal actions such as custody evaluations/suits, divorce proceedings, personal injury suits, etc. If you are considering or are involved in such actions, your CCCS counselor can refer you to another professional who may be able to assist you in these matters.

QUALITY OF SERVICE

We would like to ensure that you have the highest quality of services possible. If you should experience any concerns or have any questions about our services, please feel free to contact CCCS at (513) 889-5880.

I have read and understand this agreement:

Name: _____ Date _____

Staff: _____ Date _____

Revised 8.29.18

CORNERSTONE COUNSELING & COUNSULTING SERVICES, LLC.

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ABOUT FINANCIAL ARRANGEMENTS AND MENTAL HEALTH SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

FEE SCHEDULE

Our standard counseling fee is $100.00 payable at each visit. **(The initial diagnostic session is $120.00)** Most insurance policies cover some percentage of outpatient counseling. You should find out the following information **prior** to your first visit to our office:

1. **What is my deductible? Have I met my deductible yet?**
   You are responsible to pay the full fee of services until your deductible is met.

2. **Do I need pre-authorization for outpatient treatment?**
   Many insurance plans operate under a "pre-authorized" concept. If your counselor at Cornerstone is not "pre-authorized" to provide treatment, you may be denied payment by your insurance company.

   PLEASE NOTE: We strongly encourage you to contact your insurance company BEFORE your first session. Cornerstone will not be responsible for denial of claims if you have not notified your insurance company for pre-authorization; or, if we are not a covered provider under your insurance.

3. **What percentage of the $100 fee will your insurance company pay and what percentage of the fee are you responsible to pay?**
   Upon arrival at Cornerstone, clients are expected to pay **at least** their portion of the fee at each and every session. You should anticipate paying the full fee ($120) for the diagnostic session.

4. **Who receives the reimbursement check?**
   Sometimes insurance companies will send the check directly to us. If this happens, then (1) you will receive a credit if you "pay-as-you-go," or (2) the payment will be added to your weekly co-payment.

   Sometimes insurance companies will send the check directly to you. If this happens, then you should expect to pay the full fee for each session.

You are ultimately responsible to pay any balance that your insurance company may not cover. We realize that you may have special arrangements with a non-custodial parent for payment of medical bills; however, we do not bill third parties. You are responsible for the bill at the time services are rendered.

CANCELLATION POLICY

Because the demand for counseling is so great, we take very seriously our responsibility to be good stewards of our time and resources. **If you are unable to keep your appointment, please contact us 24 hours prior to your scheduled appointment. Failure to contact us within the 24-hour window to cancel your appointment, may result in the client being charged the FULL AMOUNT due for the session. Also, NO SHOW, or same day appointment cancellations may be charged the full amount due. We maintain a 24-hour answering service at 513-889-5880 in case an appointment must be broken.**

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

BILLING INFORMATION FORM

CLIENT:_____ GENDER: F M BIRTHDATE:_____

PRIMARY PHONE: (____)_____ SECONDARY PHONE: (___)_____
May we identify Cornerstone?_____

EMAIL ADDRESS: _____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER:_____ SOC. SEC. #:_____

SPOUSE'S NAME:_____ WORK PHONE:(___)_____

SPOUSE'S EMPLOYER:_____

NEAREST RELATIVE
NOT LIVING WITH YOU: _____ PHONE: (___)_____

PHYSICIAN: _____ PHONE: (___)_____

IN EMERGENCY CONTACT: _____ PHONE: (___)_____

WHO REFERRED YOU?_____

INSURED PARTY:_____ BIRTHDATE:_____

EMPLOYER:_____ SOC. SEC. #:_____

INSURANCE CO:_____

CLAIMS ADDRESS:_____

INS. CO. PHONE: (___)_____ POLICY:_____

I understand and agree that **regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered,** and that payment is due at the time those services are rendered. I understand that the hourly rate for the requested services is $100.00; $120 for diagnostic session. I further understand that the initial one to three sessions are for the purpose of evaluation (i.e., to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Cornerstone client. **I have read all the information on both sides of this sheet and agree to the conditions set forth. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.**

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Cornerstone, the counselors, and other Cornerstone staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill, and for issues that concern Cornerstone operations and responsibilities.

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

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INSURANCE SIGNATURE REQUIREMENT

(in lieu of insurance form)

Client: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Cornerstone Counseling & Consulting Services, LLC. to release any information acquired pertaining to the billing process.

_____ _____

Client (or guardian) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE: I authorize payment of medical benefits to Cornerstone Counseling & Consulting Services, LLC. for services rendered.

_____ _____

Client (or guardian) Date

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

To What Health Information Does This Notice Apply? Protected Health Information is information that you provide to the Provider or that the Provider creates or receives about you and your health care and treatment, including but not limited to your name, age, race, sex, and other personal identifying information, information related to your physical or mental health in the past, present, or future, information related to your care, treatment, services, and information related to payment for your care, treatment, and services (herein, "Protected Health Information" or "PHI").

Who Must Follow This Notice? The Provider is required to comply with the privacy practices described in this Notice. The Provider reserves the right to change this Notice and to make any new practices effective for PHI the Provider already has and for PHI that the Provider receives in the future. Any changes made to this Notice will be posted at The Provider's website (www.CornerstoneCCS.com) and made available to you at your next appointment.

Ways We Can Share Your PHI Without Your Written Permission:

In certain situations, described below, the Provider requires your written permission to share your PHI, however, the Provider does not need any type of permission from you to share your PHI in the following circumstances:

A. The Provider must share your PHI to provide that information to you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this Notice.

B. Sharing Your PHI for Treatment, Payment and Health Care Operations. The Provider may share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and/or perform our "Health Care Operations." This is what these terms mean:

i. Treatment: The Provider may share your PHI to provide care and other services to you, for example, to provide a mental health evaluation. In addition, the Provider may contact you to provide appointment reminders or information about treatment options.
ii. Payment: The Provider may disclose your PHI to receive payment for services that the Provider provides to you. For example, the Provider may share your PHI to request payment and receive payment from your health insurance company ("Payor") and to confirm that your Payor will pay for services that the Provider provides to you. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.
iii. Health Care Operations: The Provider may share your PHI for our health care operations, which include management, care coordination, planning, and activities that are intended to improve the quality and lower the cost of our services.

C. The Provider may share your PHI to Business Associates that perform functions on our behalf or provide the Provider with services if the information is necessary for such functions or services. Our Business Associates are required both by law and under contract with the Provider to protect the privacy of your PHI and are not allowed to share any information other than as required by law or specified in our contract.

D. Data Breach Notification Purposes. The Provider may share your PHI to provide you with notice about the unauthorized acquisition, access, or disclosure of your PHI.

E. Public Health Activities. The Provider is required or is permitted by law to report your PHI to certain government agencies and others. For example, the Provider may share your PHI for the following:

i. to report to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
ii. as required in investigations by governmental bodies, including but not limited to licensing boards, health departments, and police;
iii. to report known or suspected abuse or neglect to the appropriate public child protective services agency;
iv. to report to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
v. to attempt to prevent or lessen a serious and imminent threat to a person for the public's health or safety or to certain government agencies with special functions such as the United States Department of State.

F. Health Oversight Activities. The Provider may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicaid, are being followed.

G. Judicial and Administrative Proceedings. The Provider may share your PHI in the course of a judicial or administrative proceeding, including but not limited to in response to a Court Order or other lawful process.

H. Law Enforcement Purposes. The Provider may share your PHI with the police or other law enforcement officials as required or permitted by law, or in compliance with a Court Order or Warrant.

I. Decedents. The Provider may share your PHI with a Coroner, funeral director, or Medical Examiner, as authorized by law.

J. Workers' Compensation. The Provider may share your PHI as permitted by or required by State law relating to workers' compensation or other similar programs.

K. As Otherwise Required By Law. The Provider may share your PHI when required to do so by law, rule, or regulation not otherwise referred to above.

Uses and Disclosures of Your PHI Requiring Your Written Permission:

For any purpose other than the ones described above, the Provider may only share your PHI when you grant the Provider your written permission ("Authorization"). For example, you will need to give the Provider your Authorization to share your PHI with other people you identify, such as family members or friends.

Sharing Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you, which includes any portion of your health information that is: (1) kept in psychotherapy notes, (2) about mental health and developmental disabilities services, (3) about alcohol and drug abuse prevention, Treatment and referral, (4) about HIV/AIDS testing, diagnosis or Treatment, (5) about sexually transmitted disease(s), (6) about genetic testing, (7) about child abuse and neglect, (8) about sexual assault, or (9) about In Vitro Fertilization (IVF) (collectively, "Highly Confidential Information"). Before the Provider shares any of your Highly

Confidential Information for a purpose other than those permitted or required by law, the Provider must obtain your Authorization.

Your Rights Regarding Your PHI: Although your record is the physical property of the Provider, you have the following rights:

You have the right to be informed of our privacy practices.

Our practices related to protecting the privacy of your PHI are described in this Notice. You have the right to a paper copy of this Notice. When you first become our client, the Provider will ask you to sign an Acknowledgment of Receipt of this Notice indicating that you have received a paper copy of this Notice. You may also obtain a paper copy of this Notice anytime you visit.

A current version of this Notice can also be viewed on our website at www.CornerstoneCCS.com. Even if you have access to this Notice electronically, you are still entitled to a paper copy.

Submit your written request for a paper copy of this Notice to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

You have the right to request access to your PHI.

You have the right to inspect and/or obtain your PHI that may be used to make decisions about your care. Usually, this includes medical and billing records. In some cases, you may receive a summary.

To inspect and/or obtain a copy of your PHI, you must submit a written request to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011. The Provider may charge a reasonable fee for any copies.

In certain circumstances, the Provider may deny your request to inspect and/or copy. For example, you may not inspect and/or receive a copy of (i) psychotherapy notes, (ii) information collected for use in a civil, criminal, or administrative action, and/or (iii) certain PHI that is otherwise protected by law. If you are denied access to your PHI, you may request that the denial be reviewed. Please call the Provider at 513-889-5880 if you have further questions.

You have the right to request that the Provider disclose your PHI to others.

If you would like specific items of your PHI to be sent to someone else (for example to an attorney or to your employer), you must complete and sign our Authorization to Disclose Information form. The Provider may charge a reasonable fee for any copies.

The Authorization to Disclose Information form is available at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

When the Provider receives your completed Authorization to Disclose Information form, the Provider cannot and does not guarantee that the person to whom the information is provided will not disclose the information.

You may revoke your Authorization to Disclose Information form at any time, in writing, by mailing your revocation request to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011. Your revocation is effective upon our receipt, except if the Provider has already acted

based on your Authorization to Disclose Information form.

You have the right to request that the Provider correct your PHI.

You have the right to ask the Provider to correct PHI the Provider maintains about you if you believe the PHI is inaccurate or incomplete. Your request must be in writing and provide the reasons for the requested correction. The Provider will review your request and either make the correction or let you know why the Provider thinks our information is accurate and/or complete. If the Provider denies your request, you may give the Provider a written statement disagreeing with our decision that the Provider will keep with your PHI.

To request a correction to your PHI, mail your request to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

You have the right to request that the Provider communicate with you in a certain way or at other locations.

You have the right to request that the Provider communicates with you about your health in a certain way or at a certain location. For example, you may ask that the Provider contact you at work or by U.S. Mail. The Provider will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

You have the right to request restrictions or limitations on the sharing of your PHI.

You have the right to request restrictions or limitations on the sharing of your PHI. The Provider is not required to agree with your request, except that the Provider must agree to any request you make to restrict disclosure of specific information to your Payor, if you completely pay for the health services you request not be disclosed out of your own pocket.

You have the right to request that the Provider restricts disclosures of PHI to your family members or to others who are involved in your health care or payment for your health care. While the Provider will try to honor your request, the Provider is not required to agree to any such request.

Requests for restriction or limitation on the sharing of your PHI must be in writing and sent to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011. If the Provider does not agree, the Provider will notify you. If the Provider does agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

You have the right to request an accounting of disclosures.

You have the right to request an accounting of disclosures made during the 6 years prior to your request.

An accounting of disclosures shall not include any disclosures made (i) prior to April 14, 2003, (ii) for Treatment, Payment, and/or Health Care Operations, (iii) to you or pursuant to any authorization given by you, (iv) to correctional institutions or law enforcement officials, and (v) other disclosures for which federal law does not require the Provider to provide an accounting.

A request for an accounting of disclosures must be in writing and sent to the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

You have the right to file a complaint.

If you believe your privacy rights have been violated, you may file a complaint with the Provider at 1900 Fairgrove Avenue, Hamilton, Ohio 45011. You may also notify the Secretary of the U.S. Department of Health and Human Services at the following address:

Celeste Davis, Regional Manager
Office for Civil Rights U.S. Department of Health and Human Services
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
Voice Phone (800) 368-1019
FAX (312) 886-1807
TDD (800) 537-7697

The Provider will not retaliate against you for filing a complaint.

You have the right to express concerns or to ask questions.

If you have any concerns about the privacy of your PHI or if you have questions about this Notice, please contact the Privacy Officer at the Provider's address at 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices of the Provider.

I understand that such Notice describes how my Protected Health Information, as defined in the Notice, may be shared, and that the Notice informs me of my rights with respect to my PHI.

Name of Client:_____

Date of Birth:_____

Signature of Client or Personal Representative:_____

Printed Name of Client or Personal Representative:_____

If Personal Representative, indicate relationship:_____

Date:_____

Refusals

_____ The Individual refused to accept a copy of the Notice of Privacy Practices.

_____ The Individual received a copy of the Notice of Privacy Practices but refused to sign an Acknowledgement of Receipt.

Signature of the Provider Representative:_____

Printed Name of the Provider Representative:_____

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Personal Information Questionnaire

Name: _____ Date: _____

What are you seeking help with? _____

_____

_____

Do you have any problems with your nerves? ☐ Yes ☐ No

Has anything been worrying or bothering you? ☐ Yes ☐ No

Any problems with depression? ☐ Yes ☐ No

With your temper, do you have a: ☐ Short Fuse ☐ Medium Fuse ☐ Long Fuse

Any problems with your thinking, memory, concentration? ☐ Yes ☐ No

Have you ever seen a counselor or other mental health worker? ☐ Yes ☐ No

Have you ever had a "nervous breakdown"? ☐ Yes ☐ No ☐ Don't Know

Ever hospitalized for your nerves or emotional problems? ☐ Yes ☐ No

Anyone in your family have nerve problems? ☐ Yes ☐ No ☐ Don't Know

Any suicidal thoughts or attempts? ☐ Yes ☐ No

DEMOGRAPHIC INFORMATION

If married, is your marriage: ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

If you have children, is your relationship with them: ☐ Good ☐ Fair ☐ Poor

What other family do you have in the area? ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s)
☐ Grandfather(s) ☐ Grandmother(s) ☐ In-Law(s)

Do you: ☐ own your home ☐ Rent ☐ Other

How do you like your living arrangements? ☐ Good ☐ Fair ☐ Poor

Do you have enough money to pay your bills? ☐ Yes ☐ So-So ☐ No

Are you able to keep up with your chores/responsibilities? ☐ Yes ☐ No

Do you own/have use of a car? ☐ Yes ☐ No Do you have any pets? ☐ Yes ☐ No

Any current hobbies or interests? ☐ Yes ☐ No What? _____

BACKGROUND

Any difficulties with your birth? ☐ Yes ☐ No ☐ Don't Know

What was your father like? _____

How did you and your father get along? ☐ Good ☐ So-So ☐ Bad

What was your mother like? _____

How did you and your mother get along? ☐ Good ☐ So-So ☐ Bad

How did your parents get along? ☐ Good ☐ So-So ☐ Bad

Any brothers or sisters? ☐ Yes ☐ No

How did you and your brothers/sisters get along? ☐ Good ☐ So-So ☐ Bad

Was your childhood overall: ☐ Good ☐ So-So ☐ Bad ☐ Can't remember much

Were you abused as a child? ☐ Yes ☐ No ☐ Don't Know

How was your health as a child? ☐ Good ☐ So-So ☐ Poor

Any childhood habits? ☐ Sleepwalking ☐ Nail-biting ☐ Temper Tantrums ☐ Thumb sucking
☐ Running Away ☐ Nightmares ☐ Bedwetting ☐ Fears

Childhood social activity: ☐ Too Little ☐ About Right ☐ Too Much

Did you get into any trouble as a child? ☐ Yes ☐ No

EDUCATION

Highest grade completed? ☐ Less than 12th grade ☐ High School Grad ☐ College

Are you currently in school? ☐ No ☐ Yes – Where? _____

Any awards/honors while in school? ☐ Yes ☐ No

What kind of grades did you get? ☐ Above Average ☐ Average ☐ Below Average

Were you in sports, band, clubs, etc? ☐ Yes ☐ No

Any problems with learning? ☐ Yes ☐ No

How did you get along with classmates? ☐ Good ☐ So-So ☐ Poor

How did you get along with teachers? ☐ Good ☐ So-So ☐ Poor

MILITARY HISTORY Ever in the military? ☐ Yes ☐ No (skip this section)

Branch?_____ Mos/Job?_____

Where Stationed?_____ Dates of Service?_____

WORK HISTORY (Complete all that apply)

Are you working? ☐ No ☐ Yes, as a _____

How long have you been at this job? _____

How do you feel about your job? ☐ Enjoy it ☐ Tolerate it ☐ Dislike/Hate it

Any special job skills? ☐ No ☐ Yes – What? _____

How do you get along with your boss/supervisor? ☐ Good ☐ Fair ☐ Poor

How do you get along with your co-workers? ☐ Good ☐ Fair ☐ Poor

Accidents on the job? ☐ Yes ☐ No Problems with being absent? ☐ Yes ☐ No

Ever fired from a job? ☐ Yes ☐ No

Previous Jobs Held | How long on that job?

1. _____ _____

2. _____ _____

3. _____ _____

SOCIAL HISTORY

Do you have anyone you can talk to about your concerns? ☐ Yes ☐ No

Is your current social activity: ☐ Too Little ☐ About Right ☐ Too Much

Is there anyone you would like to see more often? ☐ No ☐ Yes – Who?_____

RELIGIOUS INVOLVEMENT

Has "spirituality/faith? ever been important to you? ☐ Yes ☐ No (skip this section)

How would you describe your current spirituality (check all that apply)?

☐ Exciting ☐ Growing ☐ Stagnant ☐ Boring ☐ Non-Existent

☐ Discouraging ☐ Frustrating ☐ Oppressive ☐ Frightening

☐ Other (describe) _____

Is your faith/spirituality helpful to you? ☐ A lot ☐ A little ☐ None

Ever participate in any unusual religious/spiritual practices? ☐ No ☐ Yes (explain)

_____

_____

What does "sin" mean to you? _____

CURRENT HEALTH

How is your health? ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Who is your family doctor? _____

When did you last see a doctor? _____ Weeks / Months / Years Ago (Circle one)

What medications are you currently taking? _____

_____

Have you ever taken tranquilizers or sedatives ("nerve pills")? ☐ Yes ☐ No

Are you allergic to any drug or medicine? ☐ No ☐ Yes – What? _____

_____

Have you ever taken (check all that apply):

☐ Amphetamines/Speed ☐ Cocaine/Crack ☐ Marijuana ☐ PCP, Angel Dust

☐ Hallucinogens (LSD, THC, Magic Mushrooms, Peyote)

☐ Inhalants (Gas, Glue, Paint Thinner) ☐ Heroin, Codeine, Morphine

Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No

Do you have any sexual concerns? ☐ Yes ☐ No ☐ Don't Know

Have you ever had any contact with the police/legal system? ☐ Yes ☐ No

FUTURE PLANS

Do you have any plans for the future (e.g., school, job change)? ☐ No ☐ Yes

What?_____

CURRENT STATUS: Please answer the following questions so that we might have a better idea of how you are doing (circle the correct number):

During the past week:	Not at all			Some			A lot
How concerned or worried have you been about your health?	0	1	2	3	4	5	6
How anxious, nervous, or tense have you been?	0	1	2	3	4	5	6
How much have you been bothered by feelings of guilt?	0	1	2	3	4	5	6
Have you felt super-efficient or like you have unlimited energy, special talents or powers?	0	1	2	3	4	5	6
How depressed have you felt?	0	1	2	3	4	5	6
How irritable or angry have you been?	0	1	2	3	4	5	6
How much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	0	1	2	3	4	5	6
Did you hear or see things around you that others did not see?	0	1	2	3	4	5	6
How much difficulty have you had with your thinking?	0	1	2	3	4	5	6
Subtotal							
						Total	

IS THERE ANYTHING ELSE YOU WOULD LIKE YOUR THERAPIST TO KNOW?